State of California Department of Consumer Affairs

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
2720 GATEWAY OAKS DRIVE, SUITE 350
SACRAMENTO, CA 95833-4304
TELEPHONE: (916) 263-3100
FAX (916) 263-3117

INSTRUCTIONS FOR COMPLETING THE CONSUMER COMPLAINT FORM

1. Legibly print or type all information.

2. Provide the full name and address of the osteopathic physician your complaint is against.

3. State your complaint in chronological order and in detail. In addition, please include dates of treatment. It is important that you be specific regarding any allegations of substandard care. Failing to be complete in your description of your complaint may result in unnecessary delays in our review. **(Please attach additional sheets of paper if necessary).**

4. Attach a copy of any supporting documents you may have in your possession pertaining to your **specific** complaint.

5. Please sign and date the complaint form.

6. Complete the medical release form included with your consumer complaint form.

   a. print or type the patient's name and date of birth at the top where indicated.
   b. print or type the name and address of the physician you are submitting the complaint about
   c. print or type the names and addresses of all other providers seen regarding your **specific** complaint (other physicians, hospitals, etc.).
   d. sign and date the authorization release.

PLEASE DO NOT MAKE ANY OTHER MARKS ON THE AUTHORIZATION RELEASE FORM.

7. Please return the completed forms to the address shown at the top of the forms.

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CONSUMER COMPLAINT FORM

Please print legibly or type

COMPLAINT REGISTERED AGAINST

1. Last Name: First Name: Middle Initial:

Office/Facility Name:

Street Address City County State Zip Code

Phone Number:

PERSON REGISTERING COMPLAINT

2. Last Name: First Name: Middle Initial:

☐ Mr. ☐ Mrs. ☐ Ms.

Mailing Address City County State Zip Code

Home Phone:	Daytime Phone:
Your Relationship to Patient:	Patient's Date of Birth:

Patient's Name:

☐ Mr. ☐ Mrs. ☐ Ms.

3. Has patient been examined/treated by another physician for this same condition? ☐ Yes ☐ No If yes, provide name and address on "Authorization for Release of Medical and Psychiatric Records and Information" form.

DETAILS OF COMPLAINT

4. Reason for Treatment:	Date(s) of Treatment:

Details of your complaint (attach additional sheets if necessary)

5. _____ _____
Signature **Date**:

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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATON

Patient Name:_____ **Date of Birth:**_____

Medical Records No:_____ **Date of Death:**_____
(if applicable) (if applicable)

Our Ref No:_____

I, the undersigned hereby authorize: ***(Please list one Physician or Facility per box)***

Physician/Facility:_____

Address:_____

Telephone Number(s):_____ **Treatment Date(s):**_____

Physician/Facility:_____

Address:_____

Telephone Number(s):_____ **Treatment Date(s)**:_____

Physician/Facility:_____

Address:_____

Telephone Number(s):_____ **Treatment Date(s):**_____

Physician/Facility:_____

Address:_____

Telephone Number(s):_____ Treatment Date(s):_____

to provide records in the course of my diagnosis and treatment, including medical, psychiatric, alcohol and drug abuse patient records (original and/or electronic computer generated) to the Osteopathic Medical Board of California, a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Osteopathic Medical Board of California completes its investigation and proceedings arising out of the investigation.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Osteopathic Medical Board of California, 2720 Gateway Oaks Drive, Suite 350, Sacramento, CA 95833. My written revocation will be effective upon receipt by the Osteopathic Medical Board of California but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me.

SIGNATURE: _____ **Date:**_____
(patient)

or

_____ **Date:** _____
(Legal Representative) (Relationship)

NOTE TO PROVIDER: Failure by a physician to provide the requested records within 15 days, or health care facility within 30 days, of receipt of the request and authorization may be construed to be a violation of the Business and Professions Code Section 2225.5 and may result in further action by the Board. This release is compliant with the requirements of HIPAA and Civil Code Section 56.11